

Case Number:	CM14-0189685		
Date Assigned:	11/20/2014	Date of Injury:	04/12/2012
Decision Date:	01/08/2015	UR Denial Date:	10/31/2014
Priority:	Standard	Application Received:	11/13/2014

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Orthopedic Surgeon and is licensed to practice in South Carolina and Georgia. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 62-year-old female who reported an injury due to heavy lifting on 04/12/2012. On 10/01/2014, her diagnoses included lumbar spondylosis without myelopathy, lumbar spinal stenosis, low back syndrome, diabetes mellitus, and hypertension. Her complaints included lumbar spine pain, rated 7/10, that radiated down both legs with numbness to both feet. She was involved in a home exercise program consisting of walking, which helped her condition. She had participated in physical therapy which exacerbated her pain. She underwent bilateral L4 and L5 selective nerve root injections which gave her relief of her low back and leg pain for approximately 2 months. She feels that her returning symptoms were intolerable and was interested in pursuing surgical intervention. Her lumbar spine ranges of motion measured in degrees were flexion 60/90 and extension 20/30. Upon examination, there was paraspinous and spinous process tenderness in the lumbar region, along with tenderness of the posterior superior iliac spine. X-rays from 03/18/2014 revealed degenerative scoliosis of the lumbar spine, apex L3-4, spondylosis throughout the lumbar spine, retrolisthesis with dynamic instability on flexion/extension at L4-5, and disc collapse at L5-S1. An MRI of the lumbar spine on 05/14/2013 revealed disc herniation, central L4-5, disc collapse and bilateral up/down neural foraminal stenosis at L5-S1. Her treatment plan recommendation was for a lumbar decompression/laminectomy L4-5, right, trans lumbar interbody fusion L5-S1 within posterior instrumentation L5-S1, posterior fusion L5-S1. Preoperative labs and DME were included with that recommendation. There was a Request for Authorization, dated 10/02/2014, in this injured worker's chart.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

Lumbar decompression and laminotomy L4-5, right, translumbar interbody fusion L5-S1 with posterior instrumentation L5-S1, posterior fusion L5-S1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back, Laminectomy/Laminotomy and Fusion

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307.

Decision rationale: The request for Lumbar decompression and laminotomy L4-5, right, translumbar interbody fusion L5-S1 with posterior instrumentation L5-S1, posterior fusion L5-S1 is not medically necessary. The California ACOEM Guidelines note that within the first 3 months after onset of acute low back symptoms, surgery is considered only when serious spinal pathology or nerve root dysfunction, not responsive to conservative treatment and obviously due to a herniated disc, is detected. Disc herniation may impinge on a nerve root, causing irritation, back and leg symptoms, and nerve root dysfunction. The presence of a herniated disc on an imaging study, however, does not necessarily imply nerve root dysfunction. Some studies show spontaneous disc resorption without surgery, while others suggest that pain may be due to irritation of the dorsal root ganglion by inflammogens released from a damaged disc in the absence of anatomical evidence of direct contact between neural elements and disc material. Therefore, referral for surgical consultation is indicated for patients who have severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies (radiculopathy) preferably with accompanying objective signs of neural compromise, activity limitations due to radiating leg pain for more than 1 month, or extreme progression of lower leg symptoms, clear clinical imaging and electrophysiologic evidence of a lesion that has been shown to benefit in both the short and long term from surgical repair and failure of conservative treatment to resolve disabling radicular symptoms. If surgery is a consideration, counseling regarding likely outcomes, risks, and benefits, and especially, expectations, is very important. Patients with acute low back pain alone, without findings of serious conditions or significant nerve root compromise, rarely benefit from either surgical consultation or surgery. Before referral for surgery, clinicians should consider referral for psychological screening to improve surgical outcomes, possibly including standard tests such as the MMPI. In addition, clinicians may look for Waddell's signs during the physical examination. Many patients with strong clinical findings of nerve root dysfunction due to disc herniation recover activity tolerance within 1 month. There is no evidence that delaying surgery for this period worsens outcomes in the absence of progressive nerve root compromise. With or without surgery, more than 80% of patients with apparent surgical indications eventually recover. Surgery benefits fewer than 40% of patients with questionable physiologic findings. Moreover, surgery increases the need for future surgical procedure with higher complication rates. In good surgery centers, the overall incidence of complications from first time disc surgery is less than 1%. However, for older patients and repeat procedures, the rate of complications is dramatically higher. Patients with comorbid conditions such as cardiac or respiratory disease, diabetes, or mental illness, may be poor candidates for surgery. Comorbidities should be weighed and discussed carefully with the

patient. Although this injured worker's MRI showed a disc herniation, there was no indication of nerve root compromise on the MRI. Additionally, there was no corroboration of any nerve root impingement with electrophysiologic testing. There was no evidence in the submitted documentation that this injured worker was counseled regarding likely outcome, risks, and benefits, and her expectations of the proposed surgery. Additionally, there was no evidence that this injured worker was referred for psychological screening or was administered any psychometric instruments. Furthermore, she does have a comorbidity of diabetes, which was not addressed in the submitted documentation. For the above reasons, this request for Lumbar decompression and laminotomy L4-5, right, translumbar interbody fusion L5-S1 with posterior instrumentation L5-S1, posterior fusion L5-S1 is not medically necessary.

Preoperative labs: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Preoperative Lab Testing

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Commode: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee & Leg, Durable Medical Equipment

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Walker: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee & Leg, Walking Aids

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.